



**PROVIDER AGREEMENT FOR RECEIPT OF
H1N1 INFLUENZA VACCINE 2009-2010**



Provider PIN# _____ Clinic/Practice Name: _____
 Clinic Address: _____
 City: _____ State: _____ Zip _____

Opt Out: My practice DOES NOT wish to participate in the H1N1 Vaccine Program.

Vaccine Delivery Address and Times:

SHIPPING ADDRESS:					
CITY:				ZIP:	
Primary Contact Name:			Backup Contact name:		
TELEPHONE:			FAX:		
DELIVERY TIMES: Please specify all days and hours your clinic is available to receive vaccine. (e.g., 9AM-3PM)	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday
	AM _____ to PM _____	AM _____ to PM _____	AM _____ to PM _____	AM _____ to PM _____	AM _____ to PM _____
Special Shipping Instructions (e.g., Closed for lunch 12-1):					

_____ **Number of persons (patients and staff) expected to be vaccinated at this site each month.**

I certify that the above delivery address, dates and times to receive vaccine shipments are correct.

Your participation in the 2009 Influenza A(H1N1) monovalent vaccine vaccination effort is greatly appreciated as a vital service that will protect individuals and the public against 2009 H1N1 influenza. The 2009 Influenza A(H1N1) monovalent vaccine has been purchased by the federal government as a means of protecting the public against 2009 H1N1 influenza. It is being made available to immunization providers working in partnership with state and local public health departments to vaccinate individuals for whom the vaccine is recommended. This Provider Agreement specifies the conditions of participation in the 2009 Influenza A(H1N1) monovalent vaccine vaccination effort in the U.S. and must be signed and submitted to the immunization program prior to receipt of the vaccine.

I understand and accept the conditions of this agreement and agree to comply with these requirements on behalf of myself and all the practitioners associated with this medical office. **I agree to inform all providers in the practice of their obligations under the agreement.** The state Department of Health or the local health jurisdiction may temporarily discontinue the provision of vaccine or may terminate this agreement at any time for failure to comply with these requirements. I may terminate this agreement at any time for personal reasons.

This agreement must be signed by the organization’s Medical Director (or equivalent individual) or other individual authorized to bind the organization to the terms of the agreement. The Medical Director’s name and Washington state medical license number must be included.

Full name of the Medical Director or equivalent (please print)

WA Medical License Number

Print the full name of the person authorized to sign this agreement

Title

Signature of the person authorized to sign this agreement

Date

Fax Completed Request to Your Local Health Jurisdiction:

LHJ Name: Public Health – Seattle & King County
LHJ Phone: 206-296-4774 LHJ Fax: 206-205-5780

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The immunization provider agrees to:

1. Administer the 2009 Influenza A(H1N1) monovalent vaccine according to the recommendations of CDC's Advisory Committee on Immunization Practices as adopted by the Centers for Disease Control and Prevention.
2. Store and handle the vaccine in accordance with the package insert provided with the vaccine including in compliance with cold chain requirements.
3. Provide a current Vaccine Information Statement to each individual before vaccination, and answer questions about the benefits and risks of vaccination, including different indications for live versus inactivated vaccines.
4. Record in the patient's medical record or in an office log the date of administration, the site of administration, the vaccine type and lot number, and the name of the immunization provider for each individual vaccinated. The record must be kept for a minimum of three years following vaccination.
5. Report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (1-800-822-7967, <http://vaers.hhs.gov/contact.htm>).

In addition, the provider:

6. Can not charge patients, health insurance plans, or other third party payers for the vaccine, the syringes or the needles as these are provided at no cost to the provider. The provider/facility is also prohibited from selling H1N1 vaccine, syringes or needles.
7. May charge a fee for the administration of the vaccine to the patient, their health insurance plan, or other third party payer. The administration fee cannot exceed the regional Medicare vaccine administration fee. If the administration fee is billed to Medicaid, the amount billed cannot exceed the state Medicaid administration fee.
8. May either administer the 2009 Influenza A (H1N1) monovalent vaccine for free to individuals who cannot afford the administration fee, or refer these individuals to a public health department clinic or affiliated public health provider for vaccination.
9. Must report the number of doses of 2009 Influenza A (H1N1) monovalent vaccine administered to individuals as requested by the state or local public health department.
10. Must report to the state health department the number of doses of vaccine that were not able to be used because the vaccine expiration date was exceeded or the vaccine was wasted for other reasons. These doses must be disposed of in accordance with state regulations for biological waste.
11. Are strongly encouraged to provide an immunization record card to the vaccine recipient or parent/guardian to provide a record of vaccination, to serve as an information source if a Vaccine Adverse Event Reporting System report is needed, and to serve as a reminder of the need for a second dose of vaccine (if necessary). Immunization cards will be included in each shipment of vaccine.
12. Agree to follow the Washington State Guidelines for H1N1 Vaccine Management. A check list for the Guidelines is attached, and the full document is available on the Department of Health website at: <http://www.doh.wa.gov/cfh/immunize/vaccine/vaccine-supply.htm>



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Please fill in this additional data for your clinic and fax it back with your provider agreement.

Provider/clinic name _____

Patient population at this clinic includes(please check all that apply):

- Health care workers (your own staff)
- Pregnant women
- Caregivers of children age < 6 months
- Persons 6 months – 24 years
- Persons 25 – 64 years with high-risk conditions

Number expected to be vaccinated in the following groups each month

- _____ Total
- _____ Staff/Health care workers
- _____ Pregnant women
- _____ Caregivers of children age < 6 months
- _____ Persons 6 months – 24 years
- _____ Persons 25 – 64 years with high-risk conditions

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